Patient Registration

Patient Information

Patient's Name: Last_____ First _____Middle_____

Social Security #:_ -_-_____ Male _____ Female _____ Date of Birth _____/_/_____

Address: _____

City/State/Zip: _____ E-mail address: _____

Home Phone #: ( ) _____ Cell ( )_____ Preferred Pronoun: _____

Race_____ Ethnicity: Hispanic or Non-Hispanic or Other _____ Primary Language : _____

Sexual Orientation:_____ Gender Identity _____ Assigned Sex at Birth _____

Marital Status: ____ Divorced ____Married ____ Partner ____Single ____Widowed ___Legally Separated _____

Emergency Contact: _____ Phone: _____ Relationship to patient: _____

Insured Employer: _____ Plant Location: _____

Name of Pharmacy: _____Location: _____

Primary physician to release reports to: _____ Phone: _____

Living Will? Yes No _____ Advanced Directive? Yes _____ No _____

Power of Attorney? Yes ____ No Organ Donor? Yes_____ No ___

(Please provide your insurance card and a picture ID to the front desk at check- in)

Primary Insurance Information

Insurance Company Name: _____ Phone#: (_____) _____-_____

Insurance Company Address: _____

Policy #: _____ Group #: _____

If patient is a MINOR, fill in responsible parent or guardian: (complete address if different from above)

Mother's Name:_____Mother's Employer: _____
_____ Mother's Date of Birth:__/_____/__Social Security #_____
_____-____-_____Work Phone: ____ Mother's address:_____
_____City/State/Zip _____

Father's Name:_____Father's Employer: _____
_____ Father's Date of Birth:_____/____/__Social Security #_____
_____-____-_____Work Phone: ____ Father's address:_____
_____City/State/Zip _____